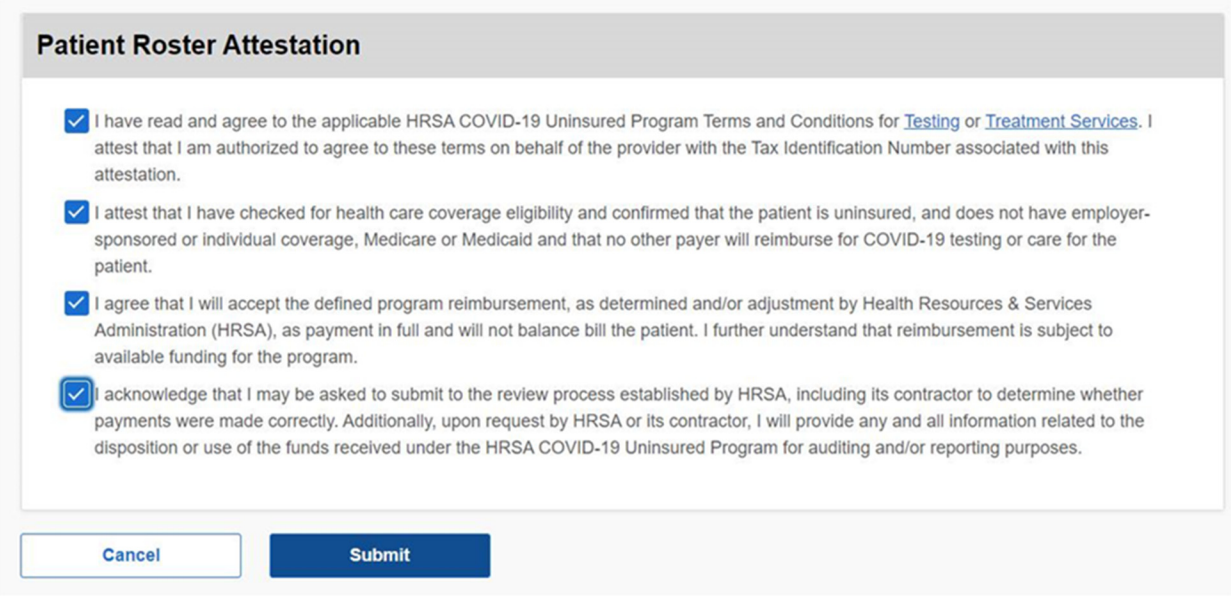
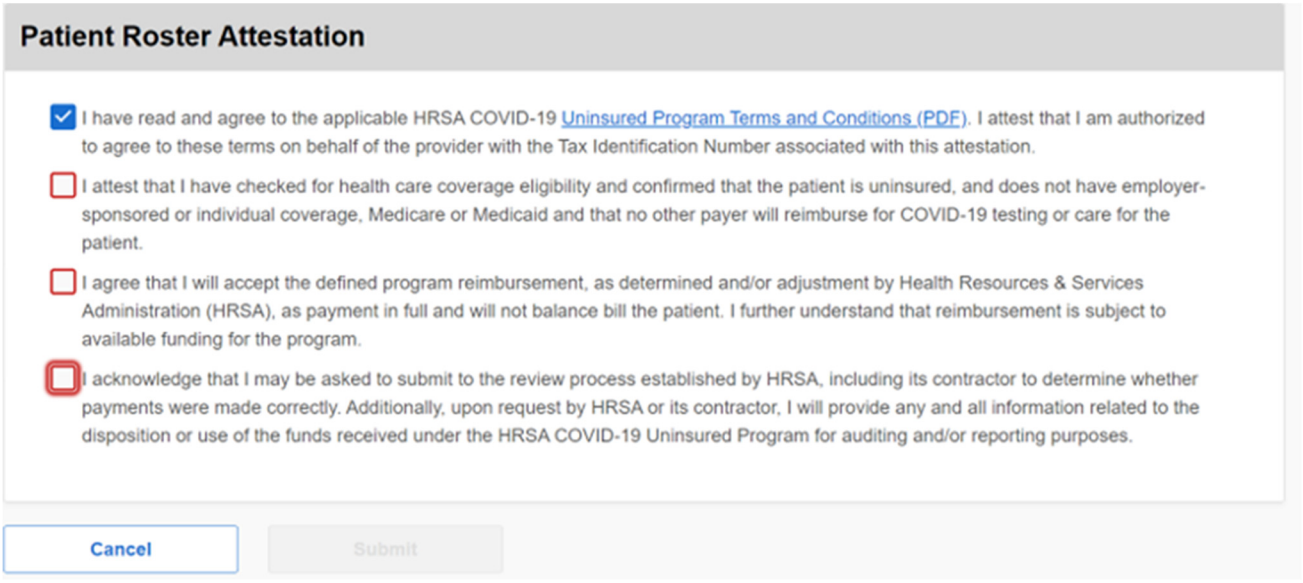
EXHIBIT A

Patient Roster Attestation from Beginning of Uninsured Program to On Or About June 18, 2021



Patient Roster Attestation from On or About June 18, 2021 to On or About December 17, 2021



Patient Roster Attestation from On or About December 17, 2021 Until the End of the Uninsured Program

Patient Roster Attestation

- ☐ I have read and agree to the applicable HRSA COVID-19 Uninsured Program Terms and Conditions (PDF). I attest that I am authorized to agree to these terms on behalf of the provider with the Tax Identification Number associated with this attestation.
- ☐ I attest that I have checked for health care coverage eligibility and confirmed that the patient is uninsured, and does not have employer-sponsored or individual coverage, Medicare or Medicaid and that no other payer will reimburse for COVID-19 testing or care for the patient.
- ☐ For vaccine administration claims, I attest that I have checked for health care coverage eligibility and confirmed that the patient is uninsured, and does not have employer-sponsored or individual coverage, Medicare or Medicaid and that no other payer will reimburse for COVID-19 vaccine administration for the patient, or their only health care coverage at the time the services were provided was foreign health coverage.
- ☐ I agree that I will accept the defined program reimbursement, as determined and/or adjustment by Health Resources & Services Administration (HRSA), as payment in full and will not balance bill the patient. I further understand that reimbursement is subject to available funding for the program.
- ☐ I acknowledge that I may be asked to submit to the review process established by HRSA, including its contractor to determine whether payments were made correctly. Additionally, upon request by HRSA or its contractor, I will provide any and all information related to the disposition or use of the funds received under the HRSA COVID-19 Uninsured Program for auditing and/or reporting purposes.